Testimony

Senate Bill 2300

Senate Industry, Business and Labor Committee

Wednesday, February 9, 2005; 9 a.m.

North Dakota Department of Health

Good morning, Chairman Mutch and members of the Senate Industry, Business and Labor Committee. My name is Kathleen Mangskau, and I am director of the Division of Tobacco Prevention and Control for the North Dakota Department of Health. I am here today to provide testimony in support of Senate Bill 2300, which expands current protections from secondhand smoke. I will also provide information about the health effects of secondhand smoke and the economic impact of smoke-free laws.

The Department of Health believes no one should use tobacco and supports efforts to reduce nonsmokers' exposure to secondhand smoke. Senate Bill 2300 is an excellent vehicle to enhance current protections from secondhand smoke.

Health Effects of Secondhand Smoke

The health hazards of secondhand smoke are well documented. There is now broad consensus in the medical and scientific communities that exposure to secondhand smoke causes death and disease in nonsmokers. According to the U.S. Centers for Disease Control and Prevention, secondhand smoke (also known as environmental tobacco smoke) is a leading cause of preventable death in this country, killing 35,000 nonsmokers each year. (CDC, 2004) In North Dakota, between 80 and 140 adults, children and babies die from secondhand smoke each year. (CDC, 1996)

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe or cigar and the smoke exhaled from the lungs of smokers. Secondhand smoke is also called environmental tobacco smoke, and exposure to secondhand smoke is called involuntary or passive smoking.

The U.S. Environmental Protection Agency and the U.S. Department of Health and Human Services National Toxicology Program report that smoke from the burning end of a cigarette contains more than 4,000 chemicals and more than 60 carcinogens, including formaldehyde, cyanide, arsenic, carbon monoxide, methane and benzene. The EPA has classified secondhand smoke as a "Group A" carcinogen – a substance known to cause cancer in humans. The EPA reports that there is no safe level of exposure to environmental tobacco smoke. (EPA, 1992) In 2000, the National Institutes of Health formally listed secondhand smoke as a known human carcinogen in its *9th Report on Carcinogens*. The EPA estimates that secondhand smoke causes approximately 3,000 lung cancer deaths in nonsmokers each year. Besides the EPA

and the NIH, many other United States environmental health, occupational health and public health authorities have condemned secondhand smoke as a health hazard, including the National Toxicology Program (2000), the National Cancer Institute (1993, 1995), the Occupational Safety and Health Administration (1994), the National Institute for Occupational Safety and Health (1990), the Surgeon General (1986) and the National Academy of Sciences (1986). A listing of the key reports documenting the health effects of secondhand smoke and a summary of findings from major studies are attached.

Numerous studies have documented the health effects associated with exposure to secondhand smoke, including lung cancer and nasal sinus cancer, heart disease deaths, and eye and nasal irritation in adults. Health effects in children include acute lower respiratory tract infections, asthma induction and exacerbation, chronic respiratory symptoms, middle ear infections, and developmental effects such as low birth-weight and sudden infant death syndrome (SIDS). The toll of secondhand smoke on children is devastating, accounting for more than 26,000 low birth weight babies, 263 cases of SIDS, nearly 300,000 pediatric asthma cases and more than 99,000 cases of ear infection. Children who are exposed to secondhand smoke have, on average, 1.5 more lost school days per year than children who are not exposed. Each year in North Dakota, 56 low birth weight babies are attributed to secondhand smoke, costing $378,247, as are 667 cases of asthma costing $540,903 and 218 cases of ear infection costing $107,778. Two of the 10 SIDS deaths each year in North Dakota are attributable to smoking exposure. (American Legacy Foundation, 2004) Restaurant and bar workers, who typically have greater exposure to secondhand smoke, are at 50 percent to 100 percent increased risk for lung cancer.

Recent studies assessing the association of secondhand smoke with heart disease show that exposure to secondhand smoke increases the risk of fatal and nonfatal coronary heart disease in nonsmokers by about 30 percent. Exposure to secondhand smoke for as little as 30 minutes can increase the formation of blood clots and restrict flow to the heart, causing a heart attack. A recent study in Helena, Montana, where a smoke-free law had been implemented, showed that heart attack admissions to the local hospital were reduced by 40 percent. The CDC states, “We now have a considerable amount of epidemiological literature and laboratory data on the mechanisms by which relatively small exposures to toxins in tobacco smoke seem to cause unexpectedly large increases in the risk of acute cardiovascular disease.” (CDC, 2004)

Current Support for Smoke-Free Environments

There is growing support for smoke-free environments in North Dakota. A survey commissioned by the North Dakota Public Education Task Force on Tobacco in 2004 found that the majority of North Dakotans age 18 through 54 feel smoking should not be allowed in schools, public facilities, entertainment arenas, private businesses and restaurants. More than 86 percent of those surveyed feel that even though smoking is legal for individuals older than 18, nonsmokers have a right to breathe clean air. The study found that 97 percent believe smoking should not be allowed in elementary and

high school buildings, 89 percent believe smoking should not be allowed in public facilities, 85 percent believe smoking should not be allowed in entertainment arenas, 61 percent believe smoking should not be allowed in private businesses and other non-government work sites and 68 percent believe smoking should not be allowed in restaurants. The research also revealed that nearly 93 percent of North Dakotans would patronize restaurants in their community just as often or more often if they all went completely smoke free. Only 32 percent believe smoking should not be allowed in bars and cocktail lounges, but that percentage is up from 22 percent in 2002. A fact sheet on the study findings is attached.

Some may wonder why the U.S. Occupational Safety and Health Administration has not promulgated rules on secondhand smoke. Because of repeated Congressional admonitions that secondhand smoke is an issue best handled by states, federal regulatory agencies have been discouraged from undertaking rulemaking or research efforts to protect private-sector workers and the public. In 2001, OSHA withdrew its Indoor Air Quality Proposal and terminated the rulemaking proceeding. Since that proposal was first issued, a great many state and local governments and private employers have taken action to curtail smoking in public areas and in workplaces.

As of July 2004, 12 states had adopted state smoke-free workplace laws. Eleven states include restaurants in their smoke-free workplace laws, and seven states include bars. California and Utah were the first states to implement smoke-free laws in 1994. Ten additional states have implemented various combinations of 100 percent smoke-free provisions since 2002. Legislation is being considered in five additional states. A listing of the states with smoke-free workplace laws is attached.

California has the longest history of smoke-free workplace laws. Smoking prevalence has declined and California smokers are smoking fewer cigarettes. Accelerated reductions have been documented for heart disease deaths and lung cancer incidence rates. From 1988 through 1999, lung and bronchus cancer rates in California declined at nearly six times the rates of decline in the nation. In addition, six out of nine cancer types that have been linked to tobacco use had a lower incidence rate in California than in the rest of the United States in 1999.

<u>Economic Impact of Smoke-Free Workplace Laws</u>
Numerous studies have documented the economic impact of smoke-free policies. Well designed studies (1) are based on objective measures; (2) use data several years before and after implementation of the policy; (3) use appropriate statistical tests that test for significance, controlling for underlying trends and fluctuations in data; and (4) control for changes in economic conditions. Key findings from A *Summary of Studies Assessing the Economic Impact of Smoke-free Policies in the Hospitality Industry* by Scollo and Lal (VicHealth Centre for Tobacco Control, 2004) are quoted below.

- No negative economic impact from the introduction of smoke-free policies in restaurants and bars is indicated by the 21 studies where findings are based on

an objective measure such as taxable sales receipts, where data several years before and after the introduction of smoke-free policies were examined, where changes in economic conditions are appropriately controlled for, and where appropriate statistical tests are used to control for underlying trends and fluctuations in data. Just a few studies have found negative effects, and each of these studies is methodologically flawed.

- Studies concluding a negative economic impact have predominately based findings on outcomes predicted before introduction of policies, or on subjective impressions of estimates of changes rather than actual, objective, verified or audited data. These studies were funded primarily by the tobacco industry or organizations allied with the tobacco industry. Almost none of the studies finding a negative impact are published in peer-reviewed journals.

A study conducted in Minot, North Dakota, after implementation of the smoke-free restaurant ordinance showed no negative impact on business.

Ventilation

The tobacco industry's accommodation policy consists of the recent effort to push for ventilation standards instead of prohibitions on smoking. The Philip Morris *Options* program, for example, seeks to convince owners, operators and patrons of establishments that ventilation can alleviate the problems caused by secondhand smoke. However, there is no ventilation system guaranteed to completely eliminate the exposure of nonsmokers to secondhand smoke in a building where smoking is allowed.

According to the EPA, even minimal exposure to secondhand smoke increases the number of attacks and the severity of symptoms in children who have asthma. In addition, the EPA recognizes no safe level of exposure to Group A Carcinogens and has determined that secondhand smoke cannot be reduced to safe levels in businesses by high rates of ventilation. Even Phillip Morris USA carries a disclaimer on its website that states: "While not shown to address the health effects of secondhand smoke, ventilation can help improve the air quality of an establishment by reducing the sight and smell of smoke and by controlling the smoke drift."

The American Society of Heating, Refrigeration and Air Conditioning Engineers, ASHRAE, develops indoor ventilation standards. ASHRAE Standard 62, *Ventilation for Acceptable Indoor Air Quality*, applies only to nonsmoking areas because ASHRAE has determined that ventilation and air cleaning do not adequately remove secondhand smoke toxins from the air. Even companies that manufacture ventilation and filtration systems to remove secondhand smoke from the air state that the systems are designed only to decrease odors and increase comfort.

Legislation that relies on ventilation to protect people from the health hazards of secondhand smoke actually does nothing to protect the public's health, and gives

building owners and occupants the false impression that there is no health risk when the risk is still present. Ventilation is never fully effective in preventing smoke from penetrating to nonsmoking areas. Fact sheets on ventilation are attached.

Definitions

Well-defined terms and provisions are critical for ensuring that the interpretation, implementation and enforcement of the law accomplish the legislature's intent in enhancing the provisions of the law. The definitions of "place of public access," "places of employment," "restaurants" and "bars" raise the most questions. In Senate Bill 2300, key terms are precisely defined to prevent differing interpretations and to indicate the extent of coverage.

Conclusion

In conclusion, the effects of secondhand smoke are significant and well documented, as are the benefits of smoke-free laws. There is growing support for smoke-free laws in North Dakota. Finally, smoke-free laws have been shown to have no negative impact on businesses.

The *Surgeon General's Report on Reducing Tobacco Use* strongly recommends smoking bans and restrictions as an effective means to reduce nonsmokers' exposure to secondhand smoke. While the Department of Health would like to see no exemptions in this bill, we recognize that an incremental policy approach may be necessary to reach our ultimate goal of protecting all nonsmokers from secondhand smoke. However, exemptions to a comprehensive smoke-free law may create regulation and enforcement issues that may have a fiscal impact on our agency.

This concludes my testimony on Senate Bill 2300. I am happy to answer any questions you may have.